COUNTY OF SANTA BARBARA

ELECTION TO COMBINE COUNTY HEALTH CONTRIBUTIONS

By our signatures below, we agree that we meet the conditions stated below and elect to have the separate County medical and dental contributions for our health coverage combined into a single contribution. Upon this election, we shall maintain one health plan that covers ourselves and at least one dependent. We certify that we meet the following conditions:

- We are both regular County employees; and
- We are married to each other or registered Domestic Partners; and
- We are enrolled in the same medical and dental plans; and
- We have either employee + one dependent coverage or family coverage* (employee +2 or more dependents) for our medical and dental plans, with one of us as the primary insured person and the other as a dependent on the same policy; and
- One of us has waived his/her separate coverage.

We understand that if either of us drop coverage from the current medical or dental plan we are in, this election will be cancelled and the County contributions will be treated as if we are separately enrolled employees.

This election will be effective on _____. (This date must be the first day of the pay period. Election to combine coverage is normally effective the next pay period after signing).

PRIMARY INSURED EMPLOYEE:

_____

Employee Name

_____ _____

Signature Date

_____

Employee ID

DEPENDENT INSURED EMPLOYEE:

_____

Employee Name

_____ _____

Signature Date

_____

Employee ID

PLEASE SUBMIT THIS FORM ALONG WITH INSURANCE CHANGE FORMS TO NAME SPOUSE AS YOUR DEPENDENT. IF YOU ARE ADDING YOUR DOMESTIC PARTNER, A COUNTY STATEMENT OF DOMESTIC PARTNERSHIP AND A DOMESTIC PARTNER CERTIFICATE OF REGISTRATION MUST ALSO BE PROVIDED. ALL FORMS MUST BE RECEIVED BEFORE ELECTION CAN BECOME EFFECTIVE.